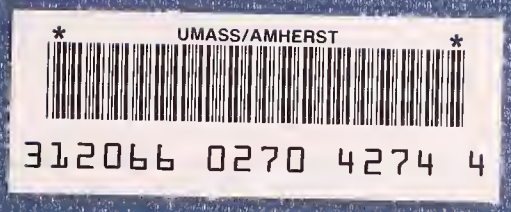

The Commonwealth of Massachusetts
Health Facilities Appeals Board
BOSTON UNIVERSITY SCHOOL OF LAW
765 COMMONWEALTH AVENUE, 16TH FLOOR
BOSTON, MASSACHUSETTS 02215

FRANCES H. MILLER, CHAIRMAN
JOSEPHUS LONG
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STEVEN TRINGALE
[redacted]
IF NO ANSWER 353-4421

Richard E. R. Meyer, M.D., Ten Taxpayer Group v.
Department of Public Health

Project No. 2-4658

FINAL DECISION

Appellant Richard E. Meyer, M.D., Ten Taxpayer Group ("Meyer") brings this appeal challenging the Department of Public Health's ("Department") grant of a determination of need (DoN) to the Vernon Medical Surgi-Center ("Vernon"), to construct an ambulatory surgical facility in the Worcester area. Vernon is a partnership composed of twenty-four individuals and St. Vincent Hospital Services, Inc., an affiliate of St. Vincent's Hospital in Worcester. Appellant Ten Taxpayer Group represents the interests of Worcester Surgical Center, Inc., ("WSI"), an affiliate of Central Massachusetts Health Care, Inc. ("CMHC"). CMHC is a licensed HMO in the Worcester area. WSI plans to open its own ambulatory surgical center in Worcester in February of 1987.

As an affiliate of a licensed HMO, WSI is exempt from DoN requirements, pursuant to M.G.L. c.111, s.25C 1/2. Nonetheless, WSI consulted with the Central Massachusetts Health Systems Agency ("CMHSA") staff in planning its facility, and CMHSA was well aware of the impact of WSI's plans on the need for ambulatory surgical services in the Worcester area at the time when Vernon's application for a DoN was being considered. [CMHSA Summary and Analysis, January, 1985, p. 8]

Appellee Vernon filed a DoN application for original licensure of a free-standing ambulatory surgery center on May 1, 1984, at a time when its partners were all private individuals. CMHSA

recommended denial on January 22, 1985, in part because WSI's proposed facility was expected to fulfill at least some of the unmet need for outpatient surgical capacity in the Worcester subarea. (Since WSI's proposal was not subject to DoN review, CMHSA had no opportunity to negotiate for a reduction in medical/surgical beds in connection with the project.) Thereafter St. Vincent Hospital's affiliate became a general partner in Vernon, and the application was re-submitted. On May 27, 1986, CMHSA recommended approval of Vernon's application, on condition that, inter alia, St. Vincent reduce its medical/surgical bed capacity by thirty beds.

On July 22, 1986, the Public Health Council granted Vernon's DoN as a pilot project for encouraging innovative forms of health care delivery under 105 CMR 100.504. The DoN was granted on condition that, inter alia, St. Vincent Hospital delicense 30 of its medical/surgical beds and reduce its present operating room capacity from 15 to 10 ORs. Meyer alleges that the Department's action in granting the DoN constituted an abuse of discretion and violated applicable provisions of law and procedure.

The essence of Meyer's argument concerns its belief that the Department cannot find "need" for ambulatory surgical facilities in the Worcester subarea given its own projected entry into Worcester's outpatient surgery market in the very near future. Notwithstanding the fact that Meyer's own project was exempt from the DoN process, it seeks to use that process to prevent entry by a competitor. Although Meyer is an HMO affiliate, it plans to make its ambulatory surgical facility available to non-HMO patients. There seems to be some question about whether Blue Cross-Blue Shield will reimburse for procedures performed on its subscribers at Meyer's facility, but presumably Meyer's financial stability will be adversely affected by Vernon's entry into the Worcester market.

There is no question about the fact that the Worcester subarea is seriously overbedded with respect to medical/surgical beds. With 144% of the need for med/surg beds met, it is the most overbedded subarea in the state. [Guidelines for Ambulatory Surgery Centers, p. 4, Figure 1 (1984).] The guidelines specifically anticipate that one of the reasons for approving hospital-affiliated ambulatory surgery facilities as pilot projects in overbedded areas, however, is to condition approval so as to achieve a reduction in inpatient bed capacity at the same time the innovative method of delivery of services is being encouraged. [Guideline III-2, p. 3.] With the

Vernon DoN approval, the Department has done just that. Vernon's DoN was not recommended for approval by the HSA until St. Vincent Hospital became affiliated with the proposal and agreed to reduce its med/surg bed capacity as one of the conditions for a favorable review. Vernon's pilot project will generate information to help the Department evaluate the overall impact of ambulatory surgery centers on the need for inpatient surgical capacity.

The Department approved Vernon's DoN only on condition that St. Vincent de-license 30 med/surg beds and give up five of its operating rooms. Four of those ORs may indeed be reincarnated in Vernon's ambulatory surgery facility, but after a careful review of the record we cannot say that the Department abused its discretion by granting Vernon's DoN under the unique circumstances of this case. The Department rarely -- if ever -- exercises its power to de-license excess beds de novo, and the DoN process offers an opportunity to achieve bed reduction in an overbedded area by agreement with the affected institution rather than by fiat. The DoN law grants the HFAB no jurisdiction to second-guess the policy views of the Department. [MGL c.111, Sect. 25E] Where, as here, there is a rational basis for the Department's decision, there is no abuse of discretion. [George J. Annas Ten Taxpayer Group et al. v. Department of Public Health, et al. (HFAB No. 4-3306, September 24, 1985)].

Meyer alleges that the Department violated 105 CMR 530 (C) by failing to consider its specific recommendations for denial of Vernon's DoN application. Meyer registered as a ten taxpayer group eight days before the Public Health Council's July 22 meeting, and by letter of July 14 simply recommended that Vernon's application by denied. Five pages attached to that letter set forth the substance of Vernon's concerns. Whether or not those concerns rise to the level of specific recommendations within the meaning of 105 CMR 100.530 (C), a careful reading of the record convinces us that the Public Health Council did indeed consider the issues raised by Meyer in making its determination. The staff summary addresses those issues [see particularly, p. 29], and the transcript shows that Meyer's representative was permitted to address the Council at some length. [Transcript, pp. 42-46] Moreover, the staff presentation specifically discussed Meyer's planned ambulatory surgery facility and its relation to Vernon's application. [Transcript, pp. 38-39] The HSA representative addressed the issue before the Public Health Council as well. [Transcript, pp. 39-41] We therefore find no violation of 105 CMR 100.530 (C).

Meyer also contends that the Department violated 105 CMR 100.561 by failing to set forth its reasons for rejection of a specific recommendation in its notice of final action. Although the Vernon DoN notice is not a model of expansive explanation in giving its reasons for refusing to follow Meyer's recommendation [pp. 3 and 4, August 25, 1986, DoN notice], neither was Meyer's letter of July 14 a model of an expansive recommendation. Whether or not it rises to the level of a "specific recommendation" within the meaning of 105 CMR 100.561, we are convinced that a reading of the DoN notice as a whole adequately responds to Meyer's position. The point of these two regulatory requirements cited by appellant is to ensure that the recommendations of 10-taxpayer groups are squarely considered by the Department, rather than ignored. A fair reading of the Vernon record and the DoN notice shows that such was the case in this instance.

Finally, Meyer contends that the Department violated 105.CMR 100.533 (B) (6) in that Vernon's capital and operating cost projections were in error. Moreover, Meyer contends that Vernon violated 105 CMR 100.533 (B) (4) in that its project as currently proposed will not comply with applicable standards of operation. After a careful review of the record we are convinced that whatever erroneous projections or potential standards violations there may be are de minimus, and correctible within the parameters of the DoN law and regulations. The appeal is therefore DENIED.

Health Facilities Appeals Board
January 19, 1987

The Commonwealth of Massachusetts
Health Facilities Appeals Board
BOSTON UNIVERSITY SCHOOL OF LAW
765 COMMONWEALTH AVENUE, 16TH FLOOR
BOSTON, MASSACHUSETTS 02215

FRANCES H. MILLER, CHAIRMAN
JOSEPHUS LONG
[redacted]
STEVEN TRINGALE
[redacted]
IF NO ANSWER 353-4421

The General Hospital Corporation
DoN Project No. 4-3368

Charles River Park Ten Taxpayer Group, Appellant
v. Department of Public Health, Appellee

FINAL DECISION

The Department of Public Health's decision granting a determination of need to the General Hospital Corporation is affirmed pursuant to the provisions of M.G.L. c. 111, § 25E.

Health Facilities Appeals Board
March 18, 1987

West Suburban Joint Diagnostic Services, Inc. v. Department of Public Health

Project No. 4-4692

Ruling on Motion/Final Decision

The March 30, 1987 joint motion of the Department of Public Health, West Suburban Joint Diagnostic Services, Inc. and the Joint Center for MRI, requests the Health Facilities Appeals Board to:

1) Affirm the January 20, 1987 action of the Department insofar as it approved the Joint Center's Determination of Need application for an MRI unit, and

2) Remand the Department's January 20, 1987 decision insofar as it pertains to West Suburban for further consideration by the Department subject to the terms and conditions set forth in the March 30 motion.

The Board deems the motion to affirm to be a motion, asserted to by the affected parties, to dismiss the appeal in so far as it may affect the January 20, 1987 action of the Department approving the Determination of Need Application of the Joint Center for MRI. The Board hereby grants such motion to dismiss.

The motion to remand West Suburban's appeal for reconsideration, subject to the terms and conditions set forth in the motion, is hereby granted because assented to by the affected parties.

Because our ruling on this motion will dispose of this appeal before the Board, this ruling should be considered the final decision.

Health Facilities Appeals Board
April 2, 1987

The Commonwealth of Massachusetts
Health Facilities Appeals Board
BOSTON UNIVERSITY SCHOOL OF LAW
765 COMMONWEALTH AVENUE, 16TH FLOOR
BOSTON, MASSACHUSETTS 02215

HEALTH FACILITIES APPEALS BOARD

CAPE COD HOSPITAL, INC. v. DEPARTMENT OF PUBLIC HEALTH

DoN Project No. 5-3384

Cape Cod Hospital, Inc. (the Hospital) has appealed the decision of the Department of Public Health (the Department) to condition approval of the Hospital's application for a Determination of Need (DoN) for construction of a dedicated ambulatory surgery center and ambulatory care facility (facility) on physician participation in the Massachusetts Medical Assistance Program (Medicaid).

The Hospital is a non-profit, 228 bed, acute care community hospital located in Hyannis, Massachusetts. It is the only hospital serving the Cape Cod area from Barnstable to Provincetown, and has been designated a sole-community provider for purposes of Medicare. Distance, traffic patterns, and lack of public transportation make it extremely difficult for area residents to use any other hospital.

Procedural History

The Hospital filed its application for a DoN on September 3, 1985. The new facility is to be constructed next to the existing surgical suite, and ambulatory surgery is to be relocated there. Southeastern Massachusetts Health Planning and Development, Inc., the health systems agency covering the Cape Cod area (HSA), recommended approval in May 1986, subject to several conditions. These included a requirement that physicians participate in Medicaid as a condition of obtaining staff privileges at the facility. On November 25, 1986, after holding public hearings, the Department voted to approve the application subject to several conditions. That decision, including the conditions of approval, was set forth in the Department's notice of DoN dated February 6, 1987. The Hospital filed a timely appeal with this Board. Amicus briefs were filed in support of the Department by the William Pastreich Ten Taxpayer Group and the Department of Public Welfare.

Issues on Appeal

The Hospital challenges only the imposition of the third condition upon the DoN. That condition states:

> Eighty-five (85) percent of all physicians in each specialty performing surgery in the ambulatory surgery center and/or treating patients in the ambulatory care center shall enroll and participate in the Medicaid Program.

The Hospital and the Department now agree that the condition prohibits the use of the facility by any physician specialty unless at least 85 percent of the physicians in that specialty who have privileges to practice at the facility are enrolled and participate in Medicaid.

The Hospital contends that conditioning approval of the new facility on physician participation in Medicaid "violates provisions of Massachusetts and federal law; that the Department abused its discretion to include the Condition; and that implementation of the Condition is unreasonable in that it will force the Hospital to act illegally and embroil it in costly and wasteful litigation . . . ."[1] In particular, the Hospital argues that there is insufficient basis in the record to permit the Department to determine that patients in the Hospital's service area have inadequate access to services, and that in the absence of such a determination, the Department is without power to require the Hospital to satisfy an unspecified standard. In addition, the Hospital contends that, even if inadequate access can be established, the Department may not lawfully remedy the problem by requiring the Hospital to guarantee a minimum rate of physician participation in Medicaid.

In reviewing the Hospital's claims on appeal, this Board "must restrict itself . . . to consideration of whether the determination appealed from was an abuse of discretion, without observance of procedure required by law or in violation of applicable provisions of law."[2] The objections raised by the Hospital are all essentially assertions that the Department abused its discretion.[3] Therefore, our analysis must be limited to an inquiry into whether the condition placed by the Department on its DoN approval constitutes an abuse of discretion. For the reasons set forth below, we conclude that it does not.

It is undisputed that the Department imposed the condition to ameliorate what it perceived to be a serious problem of inadequate access to care among Medicaid beneficiaries in the Hospital's service area. There can be no doubt that the Department has discretion to administer the determination of need program to foster equitable access

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[1] Appellant's Brief at 3.

[2] M.G.L. Ch. 111 Sec. 25E.

[3] The Hospital does not contend that the determination failed to observe any procedure required by law. While it does argue that the Condition may require the Hospital to violate applicable provisions of law, *see* page 9 infra, it does not argue that the provision itself violates any specific provision of law.

to care. Both the statute governing the DoN program[4] and the DoN Regulations specify universal availability of adequate health care services as one of the dual goals of the program. The regulations state:

> The object of the determination of need process shall be the allocation of health care resources and the improvement of health care delivery systems such that adequate health care services are made reasonably available to every person within the Commonwealth at the lowest reasonable aggregate cost. In making individual determinations, the Department shall advance this objective to the extent permitted under the governing statutes and regulations.[5]

The Department chose to ensure that the Hospital's new facility would be made reasonably available to Medicaid beneficiaries by imposing the Medicaid participation condition. The Department has the power to impose terms and conditions upon the DoN consistent with the objective of making health care services reasonably available. Section 100.550 of the Regulations provides:

> Every determination of need shall be subject to such terms and conditions as the Department may reasonably prescribe consistent with the objective of the determination of need program. (See 105 CMR 100.532)

The Department's action was not an abuse of discretion if the condition is reasonably consistent with the objective of the program and is permitted under the governing statutes and regulations.

The Hospital argues that the Department applied improper criteria and drew conclusions without factual support in determining that the Hospital's application did not demonstrate adequate provision for providing access to care for the medically needy. The Hospital claims that the Department acted arbitrarily in requiring it to ensure some measure of access to care for Medicaid beneficiaries because the Department failed to set forth standards by which the Hospital's application could be judged.

Whatever the merits of such a claim in the abstract, it cannot defeat the determination reached in this particular case. The Hospital and the

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[4]MGL ch. 111 sec. 25c. In addition, the federal law which prompted the enactment of the Massachusetts Determination of Need Law includes "the extent to which the proposed services will be accessible to all residents of the area . . ." within the minimum criteria for DoN review. 42 U.S.C. Sec. 300n-1(c)(6)(E). Regulations promulgated pursuant to the federal law specifically permit consideration of the extent to which a proposed facility will contribute to meeting the health care needs of all residents of the area, especially low income persons and minorities. 42 CFR Sec. 123.412(a). Although the federal statute was repealed effective January 1, 1987, P.L. 99-660, sec. 701(a), and the regulations rescinded effective March 30, 1987, 52 F.R. 10094, March 30, 1987, both were in effect when the Department took the action challenged. In any event, the Massachusetts DoN Law incorporated federal law to such an extent, M.G.L. Ch. 111, sec. 25H, that it must be interpreted in light of federal law.

[5]105 CMR 100.532.

Department, both independently and in concert, have been engaged in efforts to make medical and surgical services available to Medicaid beneficiaries on Cape Cod for a number of years. The Hospital has been well aware of complaints about inadequate access to care, both prior to and during the instant DoN application process.[6]

In January, 1984 the Massachusetts Hospital Association sent a memorandum on "Medicaid Non-participation by Physicians" to its member institutions, acknowledging "the difficulties created by lack of physician participation in the state Medicaid program, which it noted were "more severe on the South Shore at present . . ."[7] It further noted that the United States Court of Appeals for the Seventh Circuit had upheld Hill-Burton regulations which construed community service and uncompensated care obligations to require hospitals to use alternative methods to avoid exclusionary admission policies.[8] Among the four recommended alternatives was that of requiring physicians to accept Medicaid patient referrals as a condition for obtaining or renewing staff privileges.

It is undisputed that, having received Hill-Burton funds, a hospital has an obligation "to ensure that Medicaid beneficiaries have full access to all of its available services."[9] The Hospital participates in Medicaid, and Medicaid beneficiaries do in fact use existing Hospital facilities. Recently, the Medicaid program has taken steps to improve rate of reimbursement and claims processing procedures which have deterred physician participation in the

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[6]In 1979, the Department required the Hospital to maintain a referral procedure to ensure that Medicaid beneficiaries receive appropriate hospital-based treatment in order to comply with its community service obligations as a recipient of Hill-Burton funds. *Perry v. Cape Cod Hospital, Department of Public Health* (Department of Public Health Adjudicatory Decison under the Bill-Burton Program). That decision resulted from complaints that opthalmology services were virtually unavailable to Medicaid recipients because only one ophthalmologist with Hospital privileges was enrolled in Medicaid. (Today no ophthalmologist on staff at the Hospital participates in Medicaid.) In that decision, the Department noted, "The Community Service Regulations place an affirmative obligation on a Hill-Burton hospital to insure that in each of its departments, sub-departments and services there is a sufficient number of Medicaid provider physicians (or nonprovider physicians who will treat Medicaid patients without charge) to assure equal access for Medical Assistance patients." *Id.*

In the early 1980's, when the Hospital's staff obstetrician/gynecologists withdrew from participation in Medicaid, the Hospital established a similar referral system for pre-natal, delivery, and post-partum care for Medicaid beneficiaries. This system was replaced by a contract with one physician (increased to two for a short period) to serve Medicaid and all other uninsured patients during a ten-hour per week clinic.

[7]Staff Summary, Attachment I.

[8]*American Hospital Association v. Schweiker*, 721 F.2d 170 (7th Cir. 1983).

[9]42 CFR 124.603(d)(2).

program in the past.[10] However, the rate of participation in Medicaid among the Hospital's medical staff has not improved materially. All parties involved in the review of the Hospital's application for a DoN were keenly aware of its history of difficulty in providing services to Medicaid beneficiaries.

The HSA had been aware of problems with Medicaid beneficiaries' access to care on the Cape since at least November of 1984, when it held hearings on the issue of access.[11] In considering the application in March, 1986, the HSA posed the following questions to the Hospital:

> 14. Medicaid access (and in the past, Medicare assignment) has been a major problem on the Cape . . . . What steps has the Hospital considered to improve access for Medicaid and Medicare recipients to physicians who will use the [facility]? Please provide the reasons behind the possible acceptance or rejection of each option considered.
>
> 17. c. How many surgeons (by specialty) currently are enrolled in Medicaid?
>
> 18. Has the Hospital taken any steps, in conjunction with the Medicaid program, to encourage physicians to enroll in Medicaid?[12]

In response to these questions, the Hospital reported that it had considered conditioning hospital privileges on the acceptance of Medicaid provider status, but rejected that option because it considered Medicaid a voluntary program, because the hospital was a sole community provider, because it believed it had mechanisms to care for such patients, and because it believed Medicaid access to be a state-wide issue. The Hospital did not note any of the objections raised on appeal before this Board, nor did it contest the statement that Medicaid access has been a major problem on the Cape. Its own responses indicated that only 25 of 41 surgeons on its staff participated in Medicaid, none of four in ophthalmology, one of nine in OB/GYN, and one of three in ear, nose and throat.[13]

The HSA again focused attention on the problem of access at its February 1986 hearing.[14] At its May 22, 1986 meeting, the agency found that the continued low rate of physician participation in Medicaid jeopardized

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[10]Staff Summary, Attachment III.

[11]While no state agencies other than the HSA were contacted, the HSA had participated in the planning process for a freestanding surgery center affiliated with the hospital which proposed similar services to those intended for the new facility. The DoN application for the freestanding center was filed in May, 1984, the HSA recommended denial, and it was later withdrawn in favor of the new facility. Staff Summary, p. 4, 18-19.,

[12]Questions Submitted to CCH by Southeastern Massachusetts Health Planning and Development, Inc. and CCH'S Answers.

[13]*Id.*

[14]Staff Summary, Attachment I.

access to physician services at the Hospital for low-income Cape residents.[15] It recommended approval of the DoN subject to several conditions intended to alleviate the access problem, including a requirement that all physicians using the facility participate in Medicaid as a condition of obtaining staff privileges there.[16]

The Department conducted public hearings in March 1986 and heard testimony concerning patients' inability to receive timely orthopedic, obstetric/gynecological, and ophthalmological care. In addition, it received letters complaining of difficulties in access to care in a variety of specialties. The Department also received written comments from the Department of Public Welfare and oral testimony from the Medical Director of the Medicaid program concerning physician participation in Medicaid. The Department's DoN staff concluded that the evidence supported the claims of an inadequate number of Medicaid provider specialists in OB/GYN and ophthalmology.[17] The staff originally recommended conditioning approval on Medicaid enrollment and participation by all physicians performing surgery in the ambulatory surgery center and/or treating patients in the ambulatory care center.[18] After considering the Hospital's comments to the summary, however, the staff recommended modifying the condition to require that 85% of the physicians in each specialty participate in Medicaid. The percentage was selected as consistent with that used in the agreement reached between the Massachusetts Medical Society and the Governor as a target for the Commonwealth as a whole.[19]

Only 61% of the surgeons who will use the new facility currently participate in the Medicaid program. Since all ambulatory surgery is to be removed from regular Hospital premises and provided in the new facility, such procedures will be available to Medicaid beneficiaries only if physicians using the facility participate in the program. Although the authority to admit patients is vested in physician members of the medical staff, the Hospital's Board of Trustees makes appointments to the medical staff and determines the privileges of physicians within the Hospital. Accordingly, the Hospital has the ability to comply with its obligations by ensuring that its staff physicians provide the necessary care to the uninsured and Medicaid populations.[20]

The Department's consideration of the Hospital's DoN application at the Public Health Council meeting on November 25, 1986, centered on the need to

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15*Id.*

16Staff Summary, Attachment I, HSA Staff Review and Summary of HSA Board of Directors' Action.

17Staff Summary, pp. 19-20.

18Staff recommended against imposing a condition that the Hospital provide free care because the Hospital was already bound to do so under *Perry v. Cape Cod.*

19Staff Response to CCH Comments on Staff Summary, dated November 25, 1986 (issued Nov. 18, 1986); Transcript of the Public Health Council Meeting, p. 6.

20105 CMR 100.552.

ensure Medicaid beneficiaries access to care at the Hospital.[21] The Record reveals that the Department considered not only the collected history of problems involving access to care at the Hospital, but also statistical evidence of disparities in the volume of Medicaid services provided and physician participation in Medicaid. It also considered testimonial and written evidence of obstacles faced by patients in locating Hospital staff physicians to provide care. In particular, the Department considered whether the rotational physician referral system and OB/GYN clinic enabled Medicaid beneficiaries to obtain adequate services at the Hospital.

The Hospital argues that the evidence could be interpreted to show merely that the referral system functioned poorly and that, were it properly implemented, it could be effective. The Hospital has had more than seven years to try to make its referral system work, or to initiate a satisfactory means of enabling Medicaid patients to obtain care. Since it did neither, the Department could reasonably conclude that an alternative method of ensuring access to services was warranted.

In essence, the Hospital disagrees with the Department's evaluation of the Record. The Department concluded from the evidence before it that the Hospital has failed to insure that Medicaid beneficiaries receive care when needed. Whether or not particular statements in the Record are capable of more than one interpretation, the Department's view of the record as a whole cannot fairly be said to have been arbitrary. The Hospital had the obligation to present evidence supporting its contention that the new facility would be available to Medicaid beneficiaries for medically necessary services. In the absence of such evidence, the Department did not abuse its discretion by concluding that a determination of need was warranted only if the new facility would be reasonably available to Medicaid beneficiaries.

We think the Hospital is correct in arguing that the condition may have the effect of forcing physicians who wish to use the new facility to enroll and participate in the Medicaid program against their will. This effect would be achieved if the Hospital denies privileges to practice in the facility to non-participating physicians, who nonetheless desire to practice in the Cape Cod area. The Hospital argues, however, that because participation in Medicaid is currently not mandatory, the Department may not require Medicaid participation without violating federal and state law. We find this argument unpersuasive for two reasons.

First, we have not been referred to any statute, regulation or court decision which supports the contention that the federal or state Medicaid statute requires participation to be voluntary. Indeed, the recent decision of the First Circuit Court of Appeals in *Massachusetts Medical Society v. Dukakis*,[22] points in the opposite direction. That case found that while the federal Medicare statute recognizes and permits the practice of balance billing, it does not preempt state power to require physicians to accept Medicare assignment. The First Circuit decision suggests, at the very least, that

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[21] Transcript of the Public Health Council Meeting, pp. 3-53.

[22] ____ F.2d _____ (No. 86-1575, March 30, 1987) (Slip Opinion).

the state retains certain powers to regulate the practice of physicians more rigorously than does the federal government.[23]

Secondly, the condition does not purport to regulate physicians. The Department did not exercise any direct regulatory authority over physicians; it imposed the condition on the Hospital in accordance with its power under 105 CMR 100.532. While the condition does not permit the use of the facility by physicians unless a minimum rate of Medicaid participation is achieved in their specialty, individual physicians retain the freedom to choose whether they will participate in the Medicaid program.

Since the Hospital's application does not reasonably address the access issue, the alternative to approving the Hospital's DoN subject to the condition would have been to deny the DoN altogether. A Maryland court recently upheld such an agency decision in part on "the applicant's history of providing inadequate access for Medicaid beneficiaries and charity patients."[24] Denial of the DoN, however, would not alleviate the problem of access to services among Medicaid beneficiaries. Moreover, it would prevent improvement of facilities and service efficiencies for all patients in the Cape Cod area. Under the circumstances in this case, therefore, the Department did not abuse its discretion in granting conditional approval. We view the Department's decision as a determination that the new facility would qualify for a determination of need only if it would be reasonably available to Medicaid beneficiaries, among others. The condition is therefore a reasonable means to ensure such availability.

The Hospital also argues that the condition denies equal protection of the laws in violation of the Fourteenth Amendment to the United States Constitution, in that "physicians who require access to the Facility in order to serve their patients properly will be forced to participate in the Medicaid Program or face exclusion from the Facility."[25] The Hospital does not argue, nor could it, that physicians who seek to use the facility constitute a suspect class or have any fundamental right to practice medicine in this particular facility. Accordingly, even if the condition may require the Hospital to discriminate between physicians who participate in Medicaid and those who do not in granting privileges to practice in the facility, the differential treatment must be upheld unless it bears no rational relationship to a legitimate state purpose.[26]

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[23] *See*, also, *Metropolitan Life Insurance Company v. Massachusetts*, 105 S.Ct. 2380 (1985) (finding the Massachusetts statute prescribing mandatory minimum health insurance benefits not preempted by either the Employee Retirement Income Security Act or the National Labor Relations Act).

[24] *Doctors' Hospital of Prince George's County v. Maryland Health Resources Planning Commission*, 501 A. 2d 1324, 65 Md. App. 656 (1986).

[25] Appellant's Brief at 8.

[26] *Schweiker v. Wilson*, 450 U.S. 221 (1981); *Western & Southern Life Ins. Co. v. State Board of Equalization of California*, 451 U.S. 648 (1981); *United States R.R. Retirement Bd. v. Fritz*, 449 U.S. 166 (1981); *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1973).

We have already noted that the Department imposed the condition to further the explicit statutory objective of improving the availability of health care for residents of the Commonwealth, and that, on the basis of the evidence, the condition was reasonably calculated to achieve that objective. Moreover, the condition cannot be said to violate the federal or state Medicaid statute as currently interpreted. There has been no suggestion that some other illegitimate or unwarranted purpose motivated the Department. The condition thus meets minimum rationality standards for equal protection analysis.

There is ample precedent for upholding the right of a hospital to condition staff privileges upon performance of services to patients in need.[27] The decisions reflect the accepted principle that a hospital has the right to limit the use of its facilities to physicians who comply with rules reasonably related to its lawful purpose. There is no question that the provision of services to Medicaid beneficiaries is a lawful hospital purpose. Physicians, on the other hand, have no recognized right to practice medicine in any particular hospital. The condition does not impose any constraint upon physicians who wish to practice at the Hospital's new facility different in nature from conditions ordinarily and lawfully imposed by other hospitals. All physicians remain free to practice elsewhere. The condition does not so burden a small group of physicians who wish to practice in a portion of a particular hospital that it amounts to a violation of equal protection.

Finally, the Hospital argues that compliance with the condition could expose it to the risk of liability under the antitrust laws, the Social Security Act (Medicare), and 42 U.S.C. sec. 1983. Aside from the hypothetical nature of such arguments, they do not constitute a claim of abuse of discretion. In any event, the Department took steps to confirm that the condition would not be interpreted by local Medicare authorities to require conduct inconsistent with the requirements of Medicare, thereby defeating any claim that the condition was imposed without consideration of its effect on other laws. The Hospital's remaining arguments reduce to a statement that it does not wish to defend against speculative interpretations of federal laws which may or may not be made against it in the future.

In summary, we find no merit in the claim that the Department abused its discretion in approving the Hospital's application subject to the condition at issue. We do note, however, that this appeal might not have been filed had the Department specified in more detail the kinds of evidence it would need to document the services which Medicaid beneficiaries did and did not obtain at the Hospital. If the Department had established explicit standards for providing access to services to meet the objectives of the DoN program, this entire controversy might have been avoided.

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[27] *See, Yeargin v. Hamilton Memorial Hospital*, 195 S.E.2d 8 (Ga. 1972) (requirement that physician perform emergency room back-up duties held reasonable); *Meyer v. Mass. Eye and Ear Infirmary*, 330 F. Supp. 1328 (D.C.Mass. 1971) (requirement that physician provide free treatment for clinic patients held reasonable condition on privileges); *Coker v. Hunt Memorial Hosp. Dist.*, CA-3-86-1200-H (N.D.Tex. 1986) (claim that hospital regulation requiring physician to treat indigents without compensation violated the Fifth, Thirteenth, and Fourteenth Amendments, and the antitrust laws, found not to state a cause of action).

Nevertheless, it is clear from the Record that in this case, both the Department and the Hospital were fully cognizant of the relevant facts and aware of the need for ensuring Medicaid beneficiary access to the new facility. Under the circumstances, the decision of the Department did not constitute an abuse of discretion.

The appeal is denied.

HEALTH FACILITIES APPEALS BOARD

June 11, 1987

The Commonwealth of Massachusetts
Health Facilities Appeals Board
BOSTON UNIVERSITY SCHOOL OF LAW
765 COMMONWEALTH AVENUE, 16TH FLOOR
BOSTON, MASSACHUSETTS 02215

HEALTH FACILITIES APPEALS BOARD

Accord Nursing Home, Inc. v. Department of Public Health

DoN Project No. 4-1013

Accord Nursing Home, Inc. (Accord) has appealed the decision of the Department of Public Health (the Department) to deny Accord's application for a Determination of Need (DoN) to construct a nursing home in Hingham, Massachusetts, which is located in HSA IV, Subarea 54.

Procedural History

Accord filed its application for a DoN on September 1, 1983. On the same date, three other corporations each submitted an application to construct or upgrade nursing home beds in HSA IV, Subarea 54. They were: Mediplex of Massachusetts, Inc. (Project No. 4-1020) (Mediplex), Norwell House, Inc. (Project No. 4-1008) (Norwell House), and Norwell Knoll, Inc. (Project No. 4-1025) (Norwell Knoll). The four applications were deemed comparable by the Department.

Approval of all four projects would have resulted in a bed surplus for the subarea of 131 Level I/II beds and 36 Level III beds. DoN staff found each of the applications approvable if each were standing alone (subject to some modification to meet Department requirements). However, because there was insufficient need for all four applications, DoN staff conducted a comparability analysis to determine which of the applications were superior. Based on this analysis and on the need for beds, the DoN staff recommended approval in part with conditions of the Mediplex, Norwell House and Norwell Knoll applications, and denial of the Accord application. This recommendation was adopted unanimously by the Public Health Council at its meeting on October 28, 1986.

Issues on Appeal

Accord states that it has been aggrieved in three ways:

1. that the Department abused its discretion in accepting an amendment to the Mediplex application;

2. that in the course of the comparability analysis the Department applied criteria which were not appropriate because they were not in effect at the time the application was filed; and

3. that the Department applied these criteria in such a way as to prejudice Accord's application.

By letter dated March 6, 1986, the Program Director allowed Mediplex to amend its original application by changing the site of the proposed facility from Cohasset to Randolph, and by changing its name. The site change was due to unfavorable soil percolation tests at the original site. These tests indicated that a septic system could not be installed, and that use of the site would require construction of a waste treatment plant at an additional cost of over $500,000.

Accord argues that the site amendment to the Mediplex application significantly altered the scope, financing and cost of the project by eliminating the need for the additional capital expenditure. Accord argued before this Board that the Mediplex application did not comply with Departmental requirements. It contended that absence of records demonstrating compliance with Massachusetts Environmental Protection Act (MEPA) for Mediplex's original site constitutes *prima facia* evidence that Mediplex knew that the facility as originally proposed could not be built.

Department regulations regarding amendment in effect on September 1, 1983 grant substantial discretion to the Program Director to accept proposed amendments. The only explicit limitation on the exercise of this discretion is that set forth in 105 CMR 100.350, which provides: "No amendment shall be accepted which in the opinion of the Program Director significantly alters the project in nature, scope, financing, costs, or alters or affects the Department's evaluation of the project. The decision of whether to accept an amendment shall rest with the Program Director." (105 CMR 100.350) The regulations also set forth procedural safeguards (105 CMR 100.351) to ensure that the interests of other affected parties are protected during the decision process.

The record on these four projects is voluminous and attests to the high level of competition among the facilities from the date of application. Accord submitted numerous letters objecting to the proposed Mediplex amendment (August 20, 1985, October 23, 1985, December 17, 1985, April 4, 1986). However, none of this correspondence presents substantive evidence in support of its argument that the amendment will significantly alter the scope, financing and cost of the project.

At Accord's request, the Department held a public hearing on the proposed amendment on March 26, 1986. The transcript shows that Accord offered no substantiation of its claim that the amendment significantly altered the project, other than an argument that by changing location Mediplex will change the population served within the subarea.

Department regulations in effect on September 1, 1983 do not require that environmental approval be obtained as part of the filing process. They

require only that an Environmental Notification Form (ENF) be filed with the Executive Office of Environmental Affairs (EOEA) and that the required MEPA review process be completed before final action can be taken on the DoN application (105 CMR 100.160). Further, failure to file the ENF as required does not constitute grounds for declaring an application incomplete (105 CMR 100.303).

Department regulations in effect on September 1, 1983 establish standing to make a DoN application where a person or agency has sufficient interest in the site or facility and where the site may be used for the proposed purpose. The regulations define "used for the proposed purpose" in terms of zoning regulations; they do not explicitly require building permits (105 CMR 100.306). Accord did not challenge Mediplex's standing on the zoning grounds which are required by 105 CMR 100.306.

The regulations regarding amendment allow the Program Director to exercise discretion in deciding whether a specific amendment is permissible. There is no requirement of a positive finding of good cause. Of course, the Program Director, in forming his opinion, may not disregard material evidence and may not act in an arbitrary or capricious manner. However, in this case there is little to challenge his ruling that the amendment was permissible. There is nothing in the record which demonstrates bad faith or fraud on the part of Mediplex in proposing its original site. The Mediplex application was in compliance with Department regulations. Mediplex had not violated any Department rule in failing to file a MEPA approval for the original site. Accord was unable to show that the amendment as approved would violate 105 CMR 100.350.

While the Board feels that there may well be cases in which a change in location could fundamentally alter a proposed project, we do not feel that this is such a case. Based on review of the material in the record, the applicable regulations, and the actions of the Program Director and the Department, this Board finds no failure to consider the interests of all affected parties, to review all relevant material, or to exercise reasonable judgment. We conclude, therefore, that there was no abuse of discretion in the decision to allow the Mediplex amendment.

Accord states that some criteria used to compare the four applications were inappropriate because they were not in effect on the date its application was filed, and because they were applied in ways which prejudiced Accord's application. It is important to note that, in its required threshold determination, the Department found all four applications approvable if submitted alone. Department regulations for such cases are set forth in 105 CMR 100.537 and 100.540. The purpose of comparability review is to identify, subject to the applicable standards and criteria, the differences between applications, and to determine which applications best satisfy the factors and objectives under 105 CMR 100.533 and 100.532.

Staff found that variation existed on Factors 2 (Health Care Requirements), in particular in the area of Medicaid accessibility, 4 (Standards Compliance) and 6 (Reasonableness of Costs). The areas of disagreement lie within the analysis regarding Factors 2 and 6.

With regard to Factor 2, the Department found that the other three applicants were likely to provide more services to Medicaid beneficiaries than was Accord. Medicaid accessibility is a legitimate interest of the DoN program. Both Federal regulations concerning Medicaid programs (42 CFR 123.412) and the State regulations setting forth DoN objectives (105 CMR 100.532) identify access as a special concern of this program. The 1983 DoN Memorandum on Nursing Home DoN review also identifies Medicaid access as a concern, and sets forth several data sources for examining its adequacy and the likely impact of applications on access. A 1985 Departmental Memorandum updating the process for reviewing DoN applications for nursing home beds goes beyond the 1983 Memorandum in stating the Department's intention to require that a minimum percentage of the beds approved be for Massachusetts Medicaid patients as a routine matter. The comparative analysis performed was an assessment using several data sources similar to those described in the 1983 and 1985 Memoranda. The Board agrees that the use of the 1985 Memorandum would have been inappropriate;[1] however, nothing in the record indicates that the 1985 Memorandum was in fact used. While the data [2]sources used for the analysis were perhaps crude (in particular the facility projections), the Board does not believe that either the concept or the methodology utilized goes beyond the scope of the 1983 Memorandum. Thus even if the 1985 Memorandum had been improperly considered, the Board holds that it would have been harmless error.

With regard to the analysis concerning Factor 6, Accord makes three complaints: that the Department utilized a new standard of review in comparing Accord's costs to those of projects approved since 1984 instead of the Marshall Valuation Service (MVS) Standard; that the impact of adult day health programs was not adjusted for in computing costs per square foot; and that the Department erred in designating a construction cost figure for Norwell Knoll.

With regard to the first complaint, the Board notes that the methodology for computing construction costs (construction costs per gross square foot) has remained consistent over time and was applied consistently across applicants. This has not been challenged. Accord does challenge the standard by which the costs computed are found reasonable or unreasonable. However, because each application has already been found approvable on its own, and the context is that of a comparability analysis, the Board doubts the relevance of a debate about the absolute standard used. Further, the Board notes that at Accord's request, the Department undertook a secondary analysis which was based on construction cost per bed, with construction costs adjusted to account for adult day health program cost impacts. The resulting rankings were the same as in the initial analysis. (Applicant's Responses to Staff Summaries dated October 21, 1986 at 5).

The Department's action was in fact an approval in part of Norwell Knoll's application permissible under 105 CMR 100.500, and not prejudicial per se to Accord's application. The Department judged the applications of Mediplex and Norwell House as superior and approvable comparing all factors. This

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[1] See, MGL c. 111 §25c and 105 CMR 100.540(B).

meant that the comparability analysis focused on whether either the Accord or Norwell Knoll application could provide suitable services for the 41 Level III beds remaining available for the subarea. While Accord proposed constructing a new nursing home, Norwell Knoll applied to expand an existing facility. The primary ground used for comparing Accord and Norwell Knoll's applications was not the cost contained within the applications themselves but the financial feasibility and quality considerations of approving a freestanding 41 bed Level III unit as opposed to a 60 bed Level III addition to an existing level I/II facility. The Board feels that the overwhelming nature of this legitimate consideration makes moot arguments about cost per square foot comparisons between Accord and Norwell Knoll's original proposal. Even had the Department ruled in Accord's favor on the issue of cost, its decision to approve the other three applications would not have changed.

The last issue raised by Accord is the appropriateness of considering scope of services as a criterion in evaluating comparable applications. The Board finds that the Accord application was not, as claimed, denied because of a lack of additional services. Both Mediplex and Norwell House were considered superior applications for having incorporated such services into their program planning. The Board agrees that it would be inappropriate to deny Accord's application simply because it lacked such services, but the Board finds that preference for applications containing such programs is entirely consistent with the program objectives as set forth in 105 CMR 100.532.

In summary, the Board finds that the Department's actions in the review of these applications has been within the bounds of its authority and discretion. The appeal is therefore denied. However, the Board also notes that the Department has within its control the means of eliminating or reducing the need for such appeals. More timely review by the Department of applications and more complete supporting documentation on decisions allowing amendments is clearly indicated.

[Josephus Long did not participate in this decision.]

HEALTH FACILITIES APPEALS BOARD

July 1, 1987

HEALTH FACILITIES APPEALS BOARD

Rehab Associates of New England d/b/a Rehab Institute of Central Massachusetts v. Department of Public Health

DoN Project No. 2-3350

Ruling on Appellee's Motion to Dismiss

The motion of the Department of Public Health and Fairlawn Hospital to dismiss the above-captioned appeal is hereby granted.

HEALTH FACILITIES APPEALS BOARD

July 1, 1987

HEALTH FACILITIES APPEALS BOARD

Final Decision

Rehab Associates of New England v. Department of Public Health
DoN Project No. 2-3297

Rehab Associates of New England, d/b/a Rehab Institute of Central Massachusetts (hereinafter called "RANE"), brings this appeal from the Department of Public Health's ("Department") January 20, 1987 decision[1] denying a Determination of Need ("DoN") to construct its proposed one hundred (100) bed comprehensive multidisciplinary acute rehabilitation hospital. RANE alleges the Department abused its discretion in several respects, and that it violated both its own regulations and G.L. c.111, § 25 C.

RANE applied for a DoN for this project in September of 1984. At that time, the Department's methodology for determining the need for the combined category of chronic disease and/or rehabilitation beds showed no need at all for RANE's proposed facility. RANE's application was thus kept on file pending the adoption of new Guidelines. The then-existing methodology, adopted in 1978, aggregated need for both chronic disease and rehabilitation beds on a statewide basis. If RANE's application had been acted upon within the year after it was submitted, it would have been evaluated pursuant to the 1978 methodology and would presumably have been denied. Thus RANE's claim that it was prejudiced by the Department's failure to act expeditiously on its application has little merit with regard to that initial year after filing. Mercy Hospital's 1981 DoN application to convert 11 acute care beds to rehabilitation beds was approved within that year under an institution-specific exception to the 1978 Guidelines, but any impact of that approval on RANE's 100-bed proposal for a free-standing facility was de minimus.

In September of 1985 the Department adopted new DoN Guidelines, under which a need for rehabilitation beds in the combined area of HSAs I and II ("Area A") was shown. The 1985 Guidelines also adopted the following principle to govern the approval of all rehabilitation beds:

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[1]RANE's DoN notice was dated March 4, 1987.

> [N]o new construction of . . . comprehensive inpatient rehabilitation hospital beds [should] be approved until existing resources are fully and appropriately utilized . . . . All resources including acute care hospitals, should be considered when filling this need.[2]

The Central Massachusetts Health Systems Agency ("HSA") notified RANE on September 25, 1985, that the new policy favored conversion of excess-capacity acute care beds to rehabilitation beds rather than new construction, but RANE nonetheless decided to pursue its application.[3]

RANE alleges that the Department violated G.L. c.111, § 25c and 105 CMR 100.540 (B) by basing its review on these criteria adopted subsequent to its filing date. A reasonable reading of the record, however, leads to the conclusion that although RANE had the right to be evaluated on the basis of the 1978 Guidelines, it waived its right to object to evaluation pursuant to the 1985 criteria. The 1985 Guidelines at least acknowledge some need for rehabilitation beds, while the 1978 Guidelines showed no need for rehabilitation beds at all.

RANE was aware at all times after September of 1985 that its application was being evaluated pursuant to the more favorable 1985 criteria, and the Staff Summary explicitly stated that the 1985 Guidelines had been used. The record reveals no objection by RANE to their use. More importantly, the October 28, 1986, Public Health Council meeting testimony of Philip Katz, representing RANE, acknowledged application of the 1985 criteria, but "ask[ed] the Council to take a more enlightened and dynamic view of rehab than is found in the CDRH report."[4] In other words, Mr. Katz asked the Council to go beyond the 1985 criteria, but he did not contend that the 1985 criteria were improperly applied to evaluate RANE's proposed project. The 1978 Guidelines, of course, were even less "enlightened and dynamic."

If this issue were all there were to this appeal, and the Department had simply denied RANE's application pursuant to the policy set forth by the 1985 guidelines, this would be a simple case to affirm. A somewhat more complex problem is presented, however, when the treatment accorded RANE's application is placed in the context of the six other roughly contemporaneous applications to convert acute care to rehabilitation beds in Area A, and the length of time it took to secure a decision.

These six applications to convert acute care to rehabilitation beds were:

1. Mercy Hospital - Project #1-3015 ("Mercy 1") - proposal to convert 11 acute care beds. The application was filed on August 31, 1981,

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[2]Report of the Chronic Disease and Rehabilitation Project, Executive Office of Human Services, Sept. 6, 1985 at 5.

[3]Exhibit B: Chronology of Review by Central Mass. Health Systems Agency, attached to Memorandum in Support of Appellant's Claim of Appeal.

[4]Transcript, p. 9.

not in January of 1985 as alleged by RANE.[5] The application was approved by the Public Health Council in March of 1985 as an institution-specific exception to the 1978 guidelines.

2. Fairlawn Hospital - Project #2-3350 ("Fairlawn 1") - proposal to convert thirty acute care beds. This application was filed in May of 1985. It was approved on January 20, 1987, at the same Public Health Council Meeting at which RANE's application was denied.

3. Noble Hospital - Project #1-3404 - proposal to convert fifteen beds. This application was filed in January of 1986.

4. Worcester City Hospital - Project #2-3460 - proposal to convert thirty-two beds. This application was filed in January of 1986.

5. Mercy Hospital - Project #1-3400 ("Mercy 2") - proposal to convert sixty-one beds. This application was filed in January of 1986.

6. Fairlawn Hospital - Project #2-3340 ("Fairlawn 2") - proposal to convert ninety-three beds, essentially converting the entire acute-care institution into a free-standing rehabilitation hospital. This application was filed in January of 1986.

Departmental regulations require that applications filed within the same filing period be designated as comparable when they "propose similar or reasonably interchangeable health care services for applicable service areas which are the same in whole or in significant part."[6] Applications filed within a different filing period, but within the same filing year, may be designated as comparable within the discretion of the DoN Program Director.[7] The Program Director also has discretion to designate an amended application as comparable to any pending application filed within the same filing year in which the amendment is filed.[8] No other comparability designations are provided for by the regulations. A comparability designation entitles the applicant to have its application considered "in comparison with, and disposed of at the same time as" the applications to which it has been deemed comparable, but gives rise to no substantive rights.[9] An appeal to this Board by any one of comparable applicants, however, gives rise to an automatic stay on the determinations of the others until the appeal is decided.[10]

Only Fairlawn 1 could have been deemed comparable under the regulations, since it was the only proposal filed within the same filing year as RANE, and apparently none of the proposals was amended. The regulations give the Program Director discretion with respect to such comparability

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[5] Dated cover sheet of DoN application, submitted as attachment to Memorandum of Department of Public Health in Opposition to Claim of Appeal.

[6] 105 CMR 100.020.

[7] 105 CMR 100.304 (A) (3).

[8] 105 CMR 100.304 (A) (3).

[9] 105 CMR 100.304 (B) (1) and (2).

[10] 113 CMR 1.02 (6).

designations, and he declined to exercise it in this case. Since Fairlawn 1 was a proposal to convert acute care to rehabilitation beds while RANE's application envisioned new construction of rehabilitation beds, it was not an abuse of the discretion straightforwardly and unambiguously given the Director to decline to designate the applications as comparable. Moreover, the two applications were in fact acted upon at the same January 20, 1987 Public Health Council Meeting. RANE's denial preceded Fairlawn's approval, thus affording at least part of the claimed procedural advantage of a comparability designation. It should be noted, however, that this opinion does not reach the issue of whether in no circumstances could the Program Director abuse his or her discretion by failing to make a discretionary comparability designation.

The real issue raised by RANE in this case involves not comparability but comparisons. RANE's Determination of Need letter from the Department denying its application stated that denial was based on failure to satisfy the terms of 105 CMR 100.533 (B) (6) (reasonableness of expenditures and costs) and (7) (relative merit). In particular, RANE's Maximum Capital Expenditure of $13,894,000 was found unreasonable when compared with the capital costs of similar projects, its operating costs of $11,119,000 were found unreasonable when compared with the operating costs of similar applications, and the project was found not to be the best alternative when compared with other alternatives or substitutes. RANE alleges in essence that these comparisons were arbitrary and unfair.

The regulations state that factors to be applied by the Department in making Determinations of Need require the applicant to make "a clear and convincing demonstration" that "the proposed capital expenditure and the likely operating costs are reasonable, including (a) by comparison with expenditures and costs involved in similar projects, whether existent, approved or under consideration,"[11] whether or not they have officially been deemed comparable to that of the applicant. A reasonable interpretation of the term "under consideration" would include any project for which a DoN application had been filed, but which the Department had not yet acted upon, and RANE has not challenged the underlying validity of the regulation permitting comparisons with unapproved applications. Thus a comparison of RANE's costs with those of any or all of the six other applicants for rehabilitation beds in Area A is presumptively proper, notwithstanding the lack of an official comparability designation.

RANE argues, however, that the Department abused its discretion by comparing RANE's costs, which allegedly involve qualitatively distinct intensive rehabilitation services, with those of four of the other six proposals. Mercy 1, Fairlawn 1, Noble and Worcester City Hospital all envision small rehabilitation units in acute care institutions, which allegedly will provide "less intensive" rehabilitation services. RANE contends it should properly be compared only with Fairlawn 2 and Mercy 2,[12] which if approved would also result in free-standing rehabilitation facilities. Nonetheless RANE contends

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[11] 105 CMR 100.533 (A) and (B)(6).

[12] Memorandum in Support of Appellant's Claim of Appeal, pp. 7-12. Contrary to RANE's assertion, Mercy will remain an acute care institution with a total of 383 beds, only 42 of which will be rehabilitation beds even if Mercy 2 is approved.

that the manner in which the Department compared its application with the costs of those two proposals was also an abuse of discretion.

Neither the Guidelines nor licensure standards distinguish between more and less intensive rehabilitation services as categories of rehabilitation beds. The Guidelines simply call for cost comparisons among "similar" projects. The DoN staff specifically addressed RANE's contention that it should not be compared with smaller rehabilitation units within acute care hospitals in its December 30, 1986, Staff Summary[13] The results of staff's exploration of the issue with experts at the Massachusetts Hospital Association, the American Hospital Association, the National Association of Rehabilitation Facilities and a former DoN staff analyst who had attempted the same study two years previously were reported. All concluded that no currently available information accurately compares quality, outcome or case mix differences in a manner sufficient to permit meaningful distinctions between the two types of rehabilitation settings.

Staff's own survey of Massachusetts rehabilitation providers showed, inter alia, that "intensive" rehabilitation services can be provided in small hospital-based programs, as exemplified by University Hospital's spinal cord treatment program.[14] It also revealed "a general concensus that effective rehabilitation care can be provided in either setting, and that quality is more dependent on the strengths and commitment of the leadership and providers of an individual institution than the physical setting."[15] In light of staff's findings after its relatively extensive exploration of the issue, this Board finds that it was not an abuse of discretion for the Department to compare RANE's costs for constructing a free-standing facility with those applications proposing conversion of beds to rehabilitation units within acute care institutions.

RANE also claims that the Department's comparison of RANE's costs with those of Fairlawn 2 and Mercy 2 constituted an abuse of discretion because the costs for the latter two projects were incomplete and had not been analyzed by DoN staff in any detail. This assertion is troubling, but an intensive review of the record reveals that although the projected costs for Fairlawn 2 and Mercy 2 might have been subject to revision in certain respects, they provided reasonable baseline figures for purposes of comparison with RANE's substantially higher costs.

With respect to the MAC "buy-out" issue, RANE points to the one time incentive payment of the annual MAC of a closed acute care hospital for the year prior to closure, which can remain as an expense in the acute care reimbursement system. All of the costs associated with the provision of new rehabilitation services in the "closed" facility are added to the entire health care system. RANE contends that staff's failure to include the cost of possible MAC incentive payments in its analysis fatally undercuts the rationality of the Department's cost comparisons with RANE's proposal.

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[13] Staff Summary, pp. 11-14.

[14] December 30, 1986 Staff Summary, p. 12.

[15] December 30, 1986 Staff Summary, p. 12.

Mercy will remain primarily an acute-care hospital, even if all the rehabilitation beds it has applied for are approved, so the MAC "buy-out" issue is irrelevant with regard to Mercy's costs. With regard to Fairlawn, the MAC buy-out arrangements were tentative and incomplete, but in any event any "extra costs" associated with a buy-out would occur only in the year of closure and would not constitute a continuing expense to the health care system as a whole. This Board finds that the Department's failure to calculate the precise impact of a possible MAC buy-out for Fairlawn 2 does not rise to the level of arbitrary action.

The most troubling issue presented by this appeal is the length of time it took the Department to act on RANE's application. Even when the first year of inaction before the 1985 Guidelines were promulgated is discounted, RANE's application has suffered by comparison with substantially later-filed proposals for less-expensive conversion projects. This Board does not, however, find reversible error in this particular delay. RANE had available to it at all times the mandamus remedy specifically afforded by MGL. c. 111, § 25 C. The practical effect of exercising this right might have resulted in earlier denial because of the policy favoring conversion over new construction set forth in the 1985 Guidelines, but RANE chose to wait and try to demonstrate the superiority of its proposal over possible conversion projects. We do not hold that under no circumstances could the Department's failure to act while awaiting and evaluating new proposals amount to an abuse of discretion but, given the policy of the 1985 Guidelines favoring conversion over new construction, the delay -- while extreme -- did not reach the level of reversible error.

The decision of the Department denying RANE's application for a DoN, Project # 2-3297, is affirmed.

Health Facilities Appeals Board
July 16, 1987

[Josephus Long did not participate in this decision.]